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**BEFORE THE**
**BOARD OF REGISTERED NURSING**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

| | |
|---|---|
| In the Matter of the Accusation Against:<br><br>**RUTH NDUTA WAITHAKA**<br>**35185 Trevino Trail**<br>**Beaumont, CA 92223**<br><br>**Registered Nurse License No. 609244**<br><br>Respondent. | Case No. 2013-125<br><br>**ACCUSATION** |

Complainant alleges:

**PARTIES**

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about November 14, 2002, the Board of Registered Nursing issued Registered Nurse License Number 609244 to Ruth Nduta Waithaka (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2012, unless renewed.

## JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

6. Section 2811(b) of the Code provides, in pertinent part, that the Board may renew an expired license at any time within eight years after the expiration.

## STATUTORY PROVISIONS

7. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
>
> . . . .

## REGULATORY PROVISIONS

8. Title 16, California Code of Regulations, section 1442, provides:

> As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

## COST RECOVERY

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

## FACTUAL ALLEGATIONS

10. Respondent was employed as a registered nurse at San Gorgonio Memorial Hospital (SGMH) beginning July 31, 2007. Respondent was assigned as Patient A's registered nurse at SGMH on the night shift in the Medical/Surgical on September 17, 2008, from approximately 19:00 hours to 07:00 hours on September 18, 2008. As the assigned registered nurse, Respondent was responsible for Patient A's care, which included communicating with LVNs or CNAs, obtaining reports on the patient condition, following hospital's policy and procedures, and completing appropriate reassessments and documentation.

11. Patient A was admitted to the Medical/Surgical Telemetry Unit at SGMH. during the day shift (0600 hours to 1830 hours) on September 17, 2008 at 17:25 hours. Patient A's admitting diagnoses included newly-identified weakness/paralysis, slurred speech, cerebrovascular accident (stroke) and hypertension (high blood pressure). Patient A's assessment report reflected that Patient A was to be on bed rest, required assistance from the nurses and had a history of falls. The initial care plan contained a note on September 17, 2008 at 17:36 hours stating that Patient A was at risk for falls. The Morse Fall Scale is an assessment tool used by S.G.M.H. to evaluate a patient's risk for falls. Patient A's score upon admission was documented as 45 (medium risk of fall) based on history of a fall at home 1-2 weeks prior to admission. In addition, Patient A had a lower extremity weakness, weak gait and an IV.

12. During the night shift, at approximately 5:00 hours on September 18, 2008, Patient A fell. An LVN was assigned to Patient A at the time of the fall and was aware of the fall. The LVN wrote in a late entry nursing note that she notified Respondent of Patient A's fall. The LVN contacted the physician assistant, who assessed Patient A after the fall, and documented the assessment in the Interdisciplinary Progress Notes in Patient A's medical record. Respondent and

the Charge Nurse were not aware of the physician assistant's assessment. Respondent did not reassess Patient A after the fall, did not modify the patient's Morse Fall Scale score, nor was a Quality Review Report completed per company policy. Respondent did not notify the Charge Nurse or House Supervisor of Patient A's fall.

13. Respondent and the Charge Nurse did not report Patient A's fall to the oncoming day shift beginning at approximately 6:00 hours on September 18, 2008. As a result, Patient A's plan of care was not modified, the fall risk score was not increased and the monitoring of Patient A was not increased to prevent a subsequent fall.

14. On September 18, 2008, at approximately 21:55 hours, Patient A was found lying face down outside his assigned room, the result of a second fall. Patient A sustained serious physical and neurological injuries causing deterioration in the patient's physical condition. A CT scan of Patient A's brain after the fall confirmed subarachnoid hemorrhage.[1]

15. Patient A was transferred to facility B on September 19, 2008 at 9:10 hours to obtain a higher level of care due to complications of the second fall. Patient A died on September 23, 2008 at 19:06 hours with cause of death listed as subarachnoid hemorrhage and blunt force trauma, the result of an accident.

## CAUSE FOR DISCIPLINE

**(Unprofessional Conduct – Gross Negligence)**

16. Respondent is subject to disciplinary action for unprofessional conduct under section 2761(a)(1) of the Code in that during her assigned shift at SGMH on September 17, 2008, Respondent was grossly negligent by failing to provide care which she knew or should have known jeopardized the patient's life, as is set forth in paragraphs 10 through 15 above, as follows:

a. Respondent's failure to report Patient A's fall at 0500 hours on September 18, 2008 to the oncoming nursing staff resulted in Patient A's care during the next shift to be compromised;

[1] A subarachnoid hemorrhage is a bleeding in the brain.

b. Respondent violated SGMH policies and procedures related to assessment, plan of care, fall risk and quality review report in relation to the care provided to a patient who is at risk for falls;

c. Respondent failed to obtain data about Patient A's fall risk, or communicate with the LVN and physician assistant throughout her shift in relation to her care of Patient A.

**PRAYER**

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 609244, issued to Ruth Nduta Waithaka;

2. Ordering Ruth Nduta Waithaka to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: August 13, 2012

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
*Complainant*

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